UMass Memorial
Children's Medical Center

Developmental and Behavioral Pediatrics (DBP)

DBP Mailing address:
ATT: DBP Admin
Suite S4-301 Room S4-301C46
55 Lake Avenue North
Worcester, MA01655

DBP clinic:
Benedict Building, second floor
55 Lake Avenue North
Worcester, MA 01655

Please attach a photo of your child

Parent Questionnaire

For children, younger than 5 years old

PLEASE NOTE: **We are unable to provide emergency services. If you are concerned that your child is in immediate danger of harming himself/herself or others, contact 911, an emergency service provider, and/or your child's primary care provider.**

Check our website for any questions: www.umassmemorial.org/DBP

*******PLEASE COMPLETE AND MAIL QUESTIONNAIRE BACK TO US WITHIN 3 MONTHS************

Child's Name: _____ Today's Date: _____

Nickname if any: _____ Date of Birth: _____ Age: _____ Sex: Male / Female

Ethnic Background (optional): White African-American Hispanic Native American

Asian Pacific Islander Other: _____

Person Completing Form: _____Relationship to Child _____

Child's Address: _____ _____
Street City

_____ _____ Email Address: _____
State Zip code

Parent 1 Name: _____Relationship to Child: _____

Parent 1 Address (if different from child's): _____
Street City State Zip code

Home Phone: (____) _____Cell Phone: (____) _____Work Phone:(____) _____

Parent 2 Name: _____Relationship to Child: _____

Parent 2 Address (if different from child's): _____
Street City State Zip code

Home Phone: (____) _____Cell Phone: (____) _____Work Phone:(____) _____

Language(s) spoken at home, from most-used to least:1) _____2)_____3)_____

Interpreter needed? __No __Yes

Child's Primary Care Doctor: _____Phone: (_____) _____

Doctor's Complete Address: _____

I. PARENT CONCERNS

1. Please describe your main concerns about your child:

2. When did you first worry about these problems?

3. Have you talked to your pediatrician about your concerns? When?

4. What have you tried to do about these problems in the past?

5. What are your child's special qualities and strengths?

II. CHILD'S BIRTH HISTORY

Is this child adopted? __ No __ Yes At age ___ months/years from (country)_____

	Pregnancy, Labor and Delivery History	**Yes**	**No**	**Comments**
1.	Age of mother when child was born: ____ years			
2.	Is this child a twin or triplet?			
3.	Any problems with other pregnancies? Miscarriages?			
4.	Use *in vitro fertilization* or other method of conception?			
5.	Were there any problems during this pregnancy?			
6.	Any medications prescribed? Why?			
7.	Gestational diabetes (sugar in urine)?			

8.	Any problem with blood pressure or toxemia?		
9.	Any problems with infections (including herpes)?		
10.	Smoking during pregnancy? How many packs per day?		
11.	Drank alcohol (beer, wine, etc) during pregnancy?		
12.	Any street drugs (marijuana, cocaine, etc.) used?		
13.	Any problems during labor or delivery?		
14.	Cesarean delivery? Why?		
15.	Baby was born at _____ weeks		

Newborn History		**Yes**	**No**	**Comments**
1.	Birth weight? _____ lbs. _____oz.			
2.	Were there any problems at birth or as a newborn?			
3.	Were any birth defects or birth injuries noted?			
4.	Put in Special Care or Intensive Care Nursery? ____days			
5.	Have jaundice and need phototherapy?			
6.	Very jittery or lethargic as a newborn?			
7.	Baby had to stay extra days in the hospital? ____days			

III. INFANT TEMPERAMENT

Please describe your child as an infant or toddler: _____

_____

More infant temperament…		**Yes**	**No**	**Comments**
1.	Problems with feeding in infancy?			
2.	Severe or prolonged colic or excessive crying?			
3.	Difficult temperament (irritable or demanding)?			
4.	Excessively wiggly or active?			
5.	Easily over-stimulated?			
6.	Passive, shy or withdrawn?			
7.	Didn't like to be held or cuddled?			
8.	Trouble keeping a babysitter?			

IV. CHILD'S MEDICAL HISTORY

	Yes	**No**	**Please comment below if "Yes"**
1. Problems with vision? Crossed eyes? Wears glasses?			
2. Problems with hearing?			
3. Serious or chronic health problem (such as diabetes)?			
4. Birth defect or birthmarks?			
5. Hospitalizations or surgery?			
6. Serious infections or illness (e.g. meningitis)?			
7. Serious injury, burn or broken bones?			
8. Head injury or lost consciousness?			

9. Frequent accidents or multiple minor injuries?		
10. Poisoning or exposure to toxic chemicals (e.g. lead)?		
11. History or suspicion of physical or sexual abuse?		
12. Fainting or dizziness?		
13. Seizures, convulsions or febrile seizures? staring spells?		
14. Staring episodes or spells?		
15. Motor tics (repeated blinking, squinting, head tossing)?		
16. Vocal tics (repeated grunting, throat clearing noises)?		
17 Compulsive mannerisms (hand washing, picking, counting)?		
18. Multiple ear infections? Chronic antibiotics or ear tubes?		
19. Serious nose, mouth or throat problems?		
20. Thyroid disorders or other hormone problems?		
21. Breathing or lung problems (pneumonia, asthma)?		
22. Too fast heart beat (palpitations) or chest pains?		
23. Frequent aches and pains?		
24. Problems with vomiting, diarrhea or constipation?		
25. Problems with kidneys, bladder or urine?		
26. Blood problems or anemia (iron deficiency or low blood count)?		
27. Difficulties with eating, diet or appetite?		
28. Small for age or underweight?		
29. Over eats or overweight?		
30. Problems with restless sleep or snoring?		
31. Allergies to medications? Specify.		
32. Other allergies? Specify.		
33. Any vitamin supplements? Specify.		
34. Any herbal medicines or other nutritional supplements?		
35. Any non-medical treatments (special diet, chiropractic, acupuncture, etc.)?		
36. Unusual reaction to immunization?		
36. Are immunizations up to date?		

V. CHILD'S SOCIAL DEVELOPMENT

1. Describe your child's temperament or personality. _____

_____

2. How does your child get along with adult members of the family? _____

_____

3. How does your child get along with adults outside the family?_____

_____

4. How does your child get along with siblings? _____

_____

5. How does your child get along with playmates/peers? _____

_____

VI. CHILD'S DEVELOPMENTAL HISTORY

Area of Development		My Child is Doing OK	I'm a little worried	I'm somewhat worried	I'm very worried
1.	General development				
2.	Speech and language skills				
3.	Motor skills				
4.	Feeding/Eating				
5.	Sleeping				
6.	Cognitive/thinking skills				
7.	Social skills				

Did your child seem to develop normally but then lose developmental skills? NO YES
If yes, describe: _____

The following questions are about your child's communication skills. Please answer if/when your child could…		**Not yet**	**Yes**	**At What Age?**
1.	Understand and respond to name?			
2.	Understand simple commands?			
3.	String sounds together (*uh oh, gaga, bada, dada, mama*)?			
4.	Pretend talk (with inflections that sound like conversation)?			
5.	Say first word (that he/she then used consistently)?			
6.	Put two words together (*want cookie, Mommy work, Dad car*)?			
7.	Use pronouns to refer to self and others?			
8.	Strangers understand most of what he/she says?			
9.	Attends to a short story and answers simple questions about it?			
10	Speak in fairly complex sentences?			

The following questions are about your child's motor skills. Please answer if/when your child could…		**Not yet**	**Yes**	**At What Age?**
1.	Sit up without being held or propped?			
2.	Crawl or scoot?			
3.	Walk alone?			
4.	Jump off the floor with both feet?			
5.	Throw a ball?			
6.	Catch a medium-sized ball?			
7.	Pick up small objects with thumb and one finger?			
8.	Unwrap loosely wrapped small objects?			
9.	String half-inch-sized beads on a string?			
10	Copies letters?			

The following questions are about your child's self-help skills. Please answer if/when your child could…		**Not yet**	**Yes**	**At What Age?**
1.	Feed self using spoon in scooping motion?			
2.	Feed self using fork to prick food?			
3.	Help you in dressing/undressing him/herself?			
4.	Unzip a zipper?			

5.	Unbutton front buttons?			
6.	Toilet-trained in day?			
7.	Toilet-trained at night?			
8.	Wash/dry hands by himself/herself?			

The following questions are about your child's pre-academic skills. Please answer if/when your child could…		**Not yet**	**Yes**	**At What Age?**
1.	Identify basic colors consistently?			
2.	Identify shapes consistently?			
3.	Identify several letters consistently?			
4.	Count 2-3 objects correctly?			
5.	Can state the use of objects (e.g. car, fork)?			

VII. CHILD'S BEHAVIORAL HISTORY

1. How do you usually handle misbehavior? _____

_____

2. How does your child respond to being told "no" or being corrected for misbehaving? _____

_____

3. How does your child respond to praise, rewards or positive reinforcement? _____

_____

4. Do you and your partner agree on how to handle misbehavior? Usually Agree Sometimes Agree Often Disagree

The following questions are about your child's sensory experiences.		**Never**	**Some-times**	**Often**	**Very Often**	**Office Notes**
1.	Unusually sensitive hearing or sense of smell					
2.	Bothered by how things feel (clothes, being hugged)					
3.	Over- or under-sensitive to pain					
4.	Easily over-stimulated; winds up or shuts down					
5.	Unusual or limited diet					
6.	Hurts herself/himself on purpose					
7.	Eats things that are not food ("pica")					
8.	Unaware of dangerous situations					

The following questions are about repetitive behaviors or habits.		**Never**	**Some-times**	**Often**	**Very Often**	**Office Notes**
1.	Echoes words or phrases					
2.	Hard to get child's attention					
3.	Prefers to be alone; ignores others					
4.	Does things just to get you to laugh					
5.	Handles change poorly; insists on same routines					
6.	Excessive or public masturbation					
7.	Excessive thumb-sucking or nail-biting					
8.	Other habits (e.g. pulls out hair or lashes)					

The following questions are about your child's ability to handle anxiety.		Never	Some-times	Often	Very Often	Office Notes
1.	Is fearful, anxious or worried					
2.	Doesn't try new things for fear of making mistakes					
3.	Is sad, unhappy or depressed					
4.	Has unusually hard time being away from parents					
5.	Refuses to speak except to family members					
6.	Resists going to school					

The following questions are about your child's ability to follow rules and routines. Please answer how often your child…		Never	Some-times	Often	Very Often	Too Young	Office Notes
1.	Has temper tantrums						
2.	Argues with adults						
3.	Defies or refuses to do as asked						
4.	Deliberately annoys others						
5.	Is angry or resentful						
6.	Tries to get even or takes out anger on others						
7.	Blames others for misbehavior						
8.	Bullies, threatens or intimidates others						
9.	Does serious lying or cheating						
10.	Starts physical fights						
11.	Is cruel to animals						

VIII. FAMILY COMPOSITION

Child lives with: __ Biological Mother __ Biological Father __ Stepmother __ Stepfather __Partner
__ Adoptive Mother __ Adoptive Father __ Foster Mother __ Foster Father __Guardian
__ Other Adult (e.g. grandparent or boyfriend) Specify: _____

Biological mother's name: _____

Age: ____ **Occupation:** _____ Highest level of school completed: _____

Biological father's name: _____

Age: ____ **Occupation:** _____ Highest level of school completed**:** _____

Adoptive/step/other mother name: _____ **Occupation:** _____

Highest level of school completed**:** _____

Adoptive/step/other father name: _____ **Occupation:** _____

Highest level of school completed _____

Additional adults: _____

_____

Parents' Marital Status: __ Married __ Never married __ Separated / Divorced __ Widowed

How do the parents get along with each other? _____

_____

If separated/divorced, how long? _____

_____

Contact with non-custodial parent or custody arrangements: _____

_____

_____

_____

Child care arrangements: _____

_____

_____

_____

_____

Any special circumstances in the family situation? _____

_____

_____

What does the family enjoy doing together? _____

_____

_____

_____

Child's siblings or other children living IN the home:	**Full, half, adoptive, step, etc.**	**Age**

Child's siblings NOT living in the home:	**Full, half, adoptive, step, etc.**	**Age**

IX. CHILD'S HOME LIFE

Stressful Life Experiences		**Yes**	**No**	**Office Notes**
1.	Child had a very upsetting experience (e.g. witnessed violence, physical abuse, sexual abuse, severe accident)?			
2.	Moved? Number of moves: _____			
3.	Out of home placement (foster care, residential center)			
4.	Family problems that may be bothering child?			
5.	Divorce/separations/remarriage?			
6.	Frequent arguments and/or physical abuse in home?			
8.	Serious physical illness in parent, caregiver or sibling?			
9.	Serious money or housing problems?			
10.	Concerns about safety in neighborhood?			
11.	Are there guns in the house?			

How much time per day does your child usually spend watching TV? _____

How much time per day does your child usually spend on computer/video games? _____

X. FAMILY HISTORY **Biological Family Medical and Psychiatric History** (if adopted indicate information on any known biological relatives and indicate information on adoptive family members)

Anyone in this child's biological family have:	**Yes**	**No**	**How is this person related to child:**
Attention problems/ADHD			
Behavior problems as child or teen			
Speech or language problems			
School problems			
Reading problems or dyslexia			
Seizures or neurological problem			
Unusual drug reaction			
Mental retardation			
Birth defect or genetic disorder			
Tics/Tourette's Syndrome			
Autism spectrum disorder or PDD			
Thyroid problems			
Heart problems before age 50			
Physical or sexual abuse			
Depression			
Bipolar / manic depression			
Social problems/shyness			
Anxiety or panic attacks			
Obsessive-compulsive disorder			
Schizophrenia			
Alcohol problems			
Drug problems			
Trouble with the law			

Other problems that run in biological family: _____

_____

Other problems that run in step-, adoptive or foster family: _____

_____

Any difficult circumstances in either parent's childhood (e.g. abuse, alcoholic parents)?

_____

_____

XI. CHILD'S SERVICES HISTORY

Placement, Programs and Services (now or in the past)	**# days/ week**	**# min/ session**	**Comments**
Early Intervention Program (0 to 3 years)? Name: _____			
Developmental specialist:			
Speech/Language Therapy			
Occupational Therapy?			
Physical Therapy?			
Play Group?			
Behavior Therapy (also known as ABA or Floortime)? Provider: _____			
Day Care: Name: _____			
Pre-school: Name: _____ School district: _____ Teacher: _____ Phone: _____ # of teachers/aides: _____ # students:_____ Does your child have his/her own 1:1 aide? _____			

Ever suspended from school or daycare? _____

Ever received any other special education or therapeutic services? ____ If yes, please specify: _____

_____

How satisfied are you with your child's current school placement and services?

Very Satisfied Somewhat satisfied Not satisfied

Comments: _____

_____

_____

XII. CHILD´S PREVIOUS EVALUATIONS AND TREATMENTS

Please indicate if your child has had any previous evaluations and attach any reports.

Has your child had other evaluations? (including school, psychologist, neurologist or other specialist doctors)

Year	**Professional's Name**	**Type of Testing**

MEDICAL TESTS including EEG, MRI, Chromosome test, etc.?

Year	**Type of Testing**	**Results**

Has your child received private counseling?

Therapist	Date Started	Date Stopped

Has your child taken medication for attention, behavior or emotional problems? _____Yes _____ No

Medication (e.g. Ritalin Sustained Release)	Dosage (e.g. 20 mg 3x day)	Month/year Started	Month/year Stopped	Effects or Adverse Effects

XIII. OTHER INFORMATION

Please add any other information you think may help us understand your child.

_____

_____

_____

_____

_____

Once completed, please return to:

Division of Developmental and Behavioral Pediatrics
Department of Pediatrics
Attn: DBP Admin
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55 Lake Avenue North, Worcester, MA 01655
Phone: 774-442-3028 Fax: 774-455-4229